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ABSTRACT

The case of Sherrie--whose problems included tantruming, self destructive, and aggressive behaviors--is presented to illustrate the Child Center's program to provide day treatment for emotionally disturbed and behavior disordered children, ages 3 thourgh 12. In Part A, the rationale for involving Sherrie in setting up and carrying out treatment programs is given. In Part B, a special project to raise Sherrie's self esteem is described in terms of six phases (which included periods of prompting, self-monitoring, mini-counseling, and point earning). Pre- and post-program measures are noted to indicate that Sherrie's self esteem rating and scores in the area of academic behavior were raised during the program. (SB)

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TREATMENT PROGRAMMING FOR AFFECTIVE BEHAVIOR

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The following is part of a group presentation describing one child's progress through The Child Center program. The Child Center provides day treatment for emotionally disturbed and behavior disordered children, ages three through twelve. A child, whom we have called Sherrie, is followed from intake through transition back into public schools two years later. Those aspects of The Child Center program relevant to affective behavioral programming are emphasized here; however, social and academic behaviors receive equal attention at The Child Center.

This paper deals with program planning and implementation while Sherrie was at The Child Center. First, a rationale for her involvement in setting up and carrying out treatment programs is given. Part B describes a specific project aimed at increasing her self-esteem.

PART A: Student Involvement in a Behavioral Program

At The Child Center we have found child involvement in setting up and administering programs to be a powerful intervention. Our students have, at one time or another, participated in identifying which problem behaviors they wanted to work on, monitoring their own behaviors, deciding what rewards they were willing to work for and administering their own rewards.

(Table I)

Several benefits can accrue from involving a child in program planning and implementation. The student - in this case, Sherrie - has the inside information on which problems bother her, which ones she's motivated to work on, and what rewards she's willing to work for.

Self-monitoring allows for the counting of covert behaviors, such as feelings and thoughts, critical to much affective programming.

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In a program involving a behavior which occurs in a variety of settings, it may permit continuous monitoring throughout the entire day, even though the case manager is not always with the student.

Under some circumstances, self-monitoring may be the only intervention needed to effect the desired change.

But perhaps most critically, self-monitoring may be the first step to building self-awareness in the student --- letting her see how many times she says negative things about herself, or how often she says nice things to a peer. And self-awareness must be the first step to our ultimate objective, self-management.

Finally, if Sherrie has shared in the responsibility of creating her own program, it follows that she might share the responsibility for whether it succeeds or fails. If power struggles are an issue, as they were with Sherrie, a contract agreed upon and signed by the child can operate as a potent defusing agent.

To sum up, particularly in the area of affective and social behavioral change, we have found that involving the child in the therapeutic process is a valuable technique. We see the child's participation as a carefully guided experience in managing her own life.

PART B: A Self-Esteem Project

A major concern in Sherrie's case was her extremely low self-esteem. In terms of specific behaviors:

1. Sherrie made many negative self-statements, e.g., "I can't do it," "I'm dumb."

2. She made very few positive self-statements, e.g., "I can do it," "I did a good job."

3. Sherrie often responded negatively to teacher praise. If we told her she had done a good job, for example, she might yell, "Go to hell!" or "Shut up!" or stomp away.

4. Finally, we hypothesized that her tantruming, self-destructive and aggressive behaviors were related to, if not in fact maintained by, her poor self-concept.

Given these observations and hypotheses, we designed a program to increase Sherrie's self-esteem.

(Table II)

Academic demands were reduced to increase the likelihood that Sherrie would experience success. This was coupled with the introduction of a highly valued reinforcer for completion of reading, to make it more likely that Sherrie would attempt the work.

To insure a high level of specific and positive feedback from the environment, teacher praise was monitored.

Finally, a specific program to increase Sherrie's positive self-statements was devised. We worked from the hypothesis that the number of positive self-statements correlates to self-esteem. The setting was Sherrie's 45-minute reading period.

(Table III)

In brief the phases of this program were as follows:

Phase 1: Baseline

Prior to intervention, there were virtually no positive self-statements, as shown by the six-cycle graph in Table III.

Phase 2: Prompting

During this phase we prompted Sherrie to say positive things about herself. For example, after she had completed a portion of her assignment, I would ask how she had done. If necessary, I then modeled an appropriate positive self-statement ("I did a good job," "I worked really fast," etc.) and asked her to repeat it back to me. Over the course of five weeks a low but fairly steady rate of spontaneous positive self-statements was established. We also note fewer rejections of teacher praise.

Phase 3: Baseline

Prompts were then dropped. Positive self-statements maintained for a time at a low but relatively consistent level.

Phase 4: Self-monitoring

At this point Sherrie's reading program was altered. Before she had earned a field trip and money to spend for completing her reading assignment for five consecutive days. Now she helped pick out several specific appropriate classroom behaviors and a variety of payoffs for points earned through these behaviors. Both she and I monitored her behavior.

At the same time Sherrie was asked to take data on how often she said positive things about herself. We compared data at the end of the reading period: an extremely high rate of agreement existed between teacher and self-data.

Initially, Sherrie's rate of positive self-statements increased two- or three-fold. Then it dropped to a level similar to Phase 3. This is consistent with other studies which have noted only temporary increases when self-monitoring was used alone.

Phase 5: Self-monitoring + Mini-counseling

During this phase we discussed with Sherrie how it made her feel to say positive versus negative things about herself. Sherrie was able to say that she felt good when she said positive things about herself; however, her rate remained about the same and this phase was cut short.

Although we didn't stay long with either Phase 4 or Phase 5, we suspect that the self-awareness gained through these activities will be important in Sherrie's long term self-management and maintenance. Therefore, we continued them while adding another, perhaps more potent element to the program.

Phase 6: Self-monitoring + Mini-counseling + Points Earned

The next phase allowed Sherrie to earn points by making positive self-statements. External factors interrupted this phase, so we cannot report conclusively on its success with Sherrie. As Table 3 shows, her positive self-statments increased considerably during the first week. A similar program is in progress with two other children at this time, and initial indications are that positive self-statements do increase in response to a concrete payoff.

While this reading program was underway, data was taken during other activities to determine whether any generalization was occurring. Only during math period, the setting most similar to reading, did we see any

and this was sporadic.

As noted at the beginning, we worked from the assumption that positive self-statements are observable behavioral evidence of positive self-esteem. To check our findings against more traditional measures, we looked at Coopersmith Self-Esteem Scale scores. The Coopersmith had been administered to Sherrie thirteen and eight months before initiating this program, again at the end of Phase 2, and again after one week of Phase 6. We recognize that many other changes occurred during this period of Sherrie's life, related and unrelated to The Child Center program, and Coopersmith scores cannot prove the effectiveness of this particular behavioral program.

We did find that Sherrie's score after Phase 2 was considerably higher --- almost two standard deviations --- than her earlier scores. Her final score, after one week of Phase 6, had declined slightly, but so did her defensiveness measure. Her subscores in the area of school and academic behavior in particular doubled during this program. Overall, then, the Coopersmith does seem to support our programming efforts in Sherrie's case.

TABLE I

WHY INVOLVE SHERRIE IN PROGRAM PLANNING AND IMPLEMENTATION?

1. She has the "inside" information.
   - What does she perceive as a problem?
   - What will she work to change?
   - What rewards will she work for?

2. She can count covert or internal behaviors.

3. She can monitor all day, across settings.

4. Her self-monitoring may produce behavior change.

5. Self-monitoring and the contracting process build self-awareness.

6. Sherrie's involvement implies co-responsibility and defuses power struggles.

Child Participation in Therapeutic Programming =

A Controlled Experience in Self-Management

TABLE II

PROGRAM TO BUILD SELF-ESTEEM

A) INCREASE SUCCESS BY REDUCING DEMANDS.

B) MONITOR TEACHER PRAISE TO INSURE HIGH LEVEL.

C) INCREASE POSITIVE SELF-STATEMENTS.

PHASE 1 - BASELINE

PHASE 2 - PROMPTING

PHASE 3 - BASELINE

PHASE 4 - SELF-MONITORING

PHASE 5 - SELF-MONITORING + MINI-COUNSELING

PHASE 6 - SELF-MONITORING + OCCASIONAL MINI-COUNSELING + POINTS EARNED.

TABLE III

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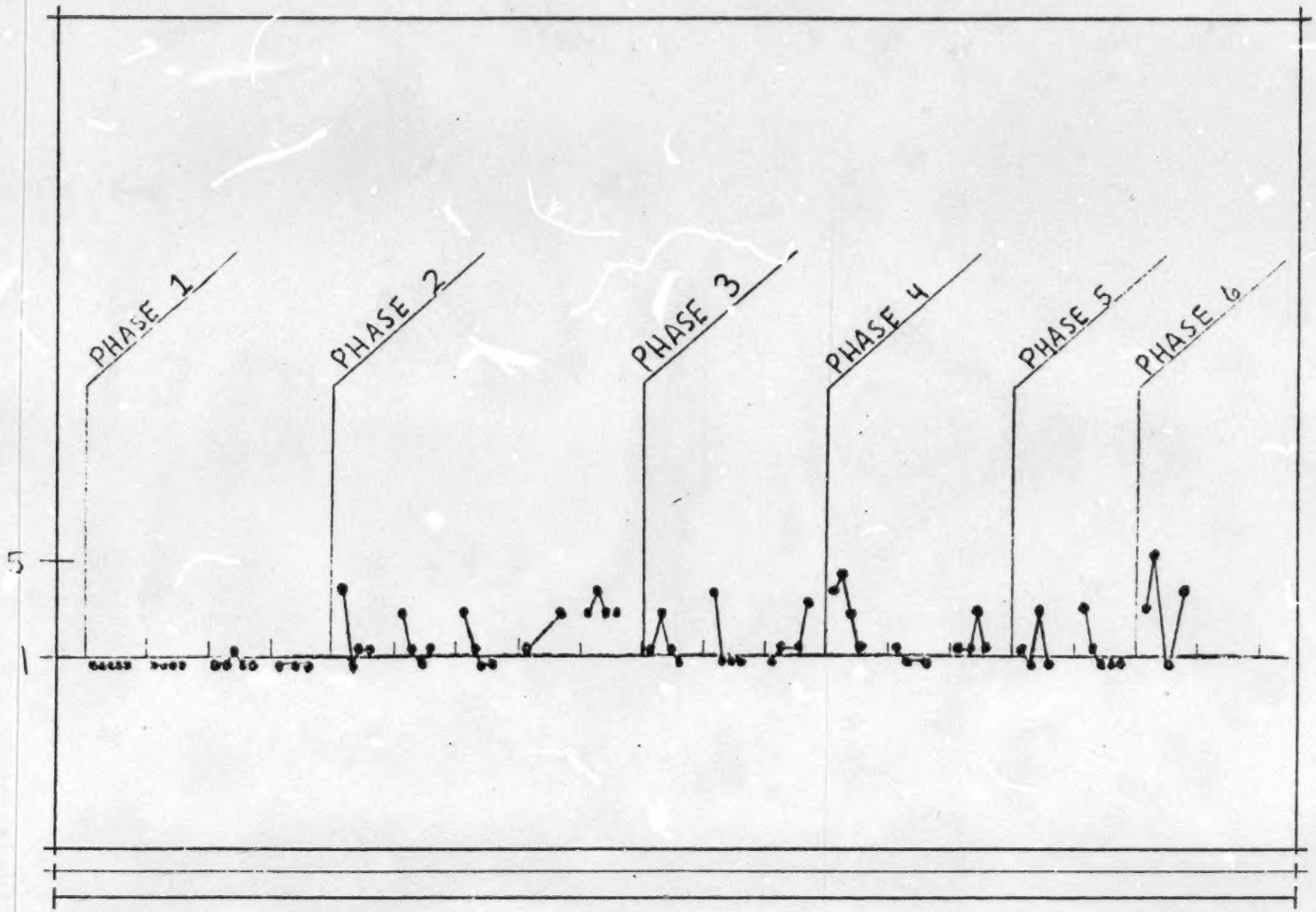

Positive self-statements

DAILY CHART TRACE (CT-8)